

END-OF-LIFE CARE AUDIT TOOLKIT

Data Dictionary

The data dictionary should be used in conjunction with the audit tool to ensure a thorough understanding of the audit tool questions and to ensure consistency in the data.

The dictionary is broken down in order of audit tool questions, the answers available for each question and any relevant definitions.

If you require any further clarification that is not contained in the data dictionary please email: mail@safetyandquality.gov.au

Admission Information	Question	Answers	Definitions
1	Audit Identifier number	Unique Number	Hospital responsible for creating unique number using Patient identifier spreadsheet .
2	Audit category for patient	Patient died on an in-patient ward, admission 4 to 48 hours Patient died on an in-patient ward, admission more than 48 hours Patient died in ICU, admission 4 to 48 hours Patient died ICU, admission more than 48 hours	See audit tool guidance for inclusions and exclusions
3	Sex	Male Female Other	
4	Date of birth	DD/MM/YYYY	

5	Admission Type	Medical – Elective Medical – Emergency Surgical – Elective Surgical – Emergency Other (please specify)	• Emergency - care that, in the opinion of the treating clinician, is required urgently e.g. via the emergency department or urgent direct admission. • Elective - care that, in the opinion of the treating clinician, is necessary and for which admission can be delayed for at least 24 hours.
6	Date and time of hospital admission	Date - DD/MM/YYYY (e.g. 01/01/2016) Time - 00:00 (e.g. 13:43) Time not documented	If admitted via emergency department – initial date presented to emergency department (not statistical admission date)
7	Date and time of death	Date - DD/MM/YYYY (e.g. 01/01/2016) Time - 00:00 (e.g. 13:43)	

8	Speciality with overall responsibility for the patient's care at the time of death	• Aged Care • Cardiology • Clinical Pharmacology • Endocrinology • Gastroenterology/Hepatology • General medicine • Haematology • Immunology • Infectious Diseases • Neurology • Oncology • Palliative care • Radiation Oncology • Rehab • Renal • Respiratory • Rheumatology Surgical • Cardiothoracics/Thoracic • Endocrine • General surgery • Orthopaedics • Maxillo facial • Neurosurgery • Plastic • Urology • Vascular • Gynaecology • Obstetrics • Anaesthetics • Emergency • Intensive Care	
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9	Where was the patient prior to hospital admission? If transferred from another hospital, where was the patient residing prior to admission to that hospital.	Home Supported living Residential care facility Other (please specify)	• Home: living independently with or without support. • Supported living: independent units, apartments or bedsitters within a community where support services are provided. • Residential care facility: Residential care facilities for people who require accommodation, meals, laundry, room cleaning and/or assistance with daily living activities.
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10	How many times was the patient admitted to an acute hospital in the 12 months prior to this hospital admission?	None 1-2 times 3-5 times More than 5 times Not known	• Include if admission to Emergency Medical Unit (EMU) / short stay unit in the emergency department. • Include if patient was an inpatient within the three months ie may have been admitted more than three months ago but still an inpatient less than three months ago. • Do not include if the patient presented to the emergency department and was discharged home . • Count only once if patient transferred between multiple acute hospitals in same hospital admission. • Include all other documented admissions.
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11	Prior to admission was there any evidence of a written advance care plan or advance health directive?	Yes No Free text	Exclude note made of EPOA (enduring power of attorney) unless this specifically discusses advance care planning. See also Question 12. Advance care plans state preferences about health and personal care, and preferred health outcomes. Advance care directive - a type of written advance care plan recognised by common law or specific legislation that is completed and signed by a competent adult. It can record the person's preferences for future care, and appoint a substitute decision-maker to make decisions about health care
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			and personal life management. Different terminology is used in Australian states and territories such as: advance health directives, Respecting Patient Choices, statement of choices, advance consent decisions, advance care statements.
12	Did the patient have a legally appointed decision-maker?	Yes No Free text	Examples include: • enduring power of attorney • substitute decision maker • guardian
13	Is there any documentation indicating the patient's preferences for care were discussed during this admission?	Yes No Free text	

14	At any time during the admission was a resuscitation plan documented?	Yes No Free text	A resuscitation plan specifies what should happen to a patient in the event that they suddenly and acutely deteriorate. Resuscitation plans specify if a patient has limitations of medical treatment. The resuscitation plan may be documented in a formal resuscitation plan or as part of the clinical record. Limitations of medical treatment may refer to specific interventions such as: • Cardiopulmonary Resuscitation • Intubation / mechanical ventilation • Defibrillation • Non-invasive ventilation (CPAP, BiPAP) • Renal replacement therapy (dialysis)
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			• ICU • HDU • Vasoactive drugs e.g. inotropes or vasopressors such as catecholamines, noradrenaline, adrenaline, vasopressin, dobutamine, metaraminol, levosimendan, milrinone • MET calls (Rapid Response Team) • Treatment with particular drugs such as antibiotics or chemotherapy. Include (Answer "Yes") if resuscitation plan is still active from previous hospital admissions and available.
15	Date and time first resuscitation plan first documented	Date - DD/MM/YYYY (e.g. 01/01/2016) Time - 00:00 (e.g. 13:43) Free text	
16	At any point was there evidence or conflicting orders that might create confusion about the patient's resuscitation	Yes No Free text	

	status or the medical treatments that were limited?		
17	At any time during the admission did the patient or family make a request that investigations/treatments be limited/ceased or that comfort care plans or palliative care referral be made?	Yes No	
18	If yes - date and time documented	Date - DD/MM/YYYY (e.g. 01/01/2016) Time - 00:00 (e.g. 13:43)	
19	Is there documented indication that the patient was actually dying?	Yes No	Words such as: • Dying • Moribund • Condition deteriorating • Palliative • Unlikely to survive • Terminal • End stage • Situation hopeless / grave • Poor prognosis / grim • Recovery unlikely • Irreversible condition

20	If yes - date and time documented	Date - DD/MM/YYYY (e.g. 01/01/2016) Time - 00:00 (e.g. 13:43)	
21	Is there evidence of communication with the patient and/or family that the patient was dying?	Yes No NA	
22	Was specialist palliative care contacted for advice?	Yes No NA	Does not include formal referrals N/A - for patients in palliative care ward
23	Was the patient referred to specialist palliative care during their admission?	Yes No NA	Referral for actual review by a specialist palliative care team member N/A - for patients in palliative care ward
24	Is there evidence that the patient was referred to hospice but died in hospital?	Yes No Free text	Reasons could be: • Hospice bed not available • Unable to be transferred to hospice • Unable to be admitted to hospice as awaiting palliative care doctor review prior to being accepted into hospice N/A - for patients in palliative care ward

25	Did the patient receive any of the following investigations/interventions in the final 48 hours of life?	Chemotherapy Radiotherapy Intubation / invasive mechanical ventilation Renal replacement therapy (dialysis) Non-invasive ventilation Vasoactive drugs CPR Anaesthetic / operation IV antibiotics IV fluids Artificial nutrition Blood tests Medical imaging Blood product transfusions Intra Aortic Balloon Pump (IABP) Cardiac catheter Other (please specify) None N/A	Non-invasive ventilation - e.g. CPAP, BiPAP (exclude chronic home CPAP) Vasoactive drugs - e.g. inotropes or vasopressors such as catecholamines, noradrenaline, adrenaline, vasopressin, dobutamine, metaraminol, levosimendan, milrinone Artificial feeds - NG, PEG, TPN Medical imaging - x-ray, CT, MRI
26	Was the patient admitted to the ICU at any time during their admission?	Yes No Free text	
27	Were there any other specialist referrals for the patient during this admission?	Yes No Free text box to list relevant specialties	Could include: • Neurology • Respiratory • Cardiology • Nephrology • Gastroenterology • Hepatology • Endocrinology • ICU (medical - not as part of MET)

			• ICU liaison (nursing) • Surgical (specify)
28	Did the patient experience any MET reviews during their hospital admission?	Yes No	
	Optional Questions-Resuscitation plans		
29	Date and time of first resuscitation plan	Date - DD/MM/YYYY (e.g. 01/01/2016) Time - 00:00 (e.g. 13:43) Time not documented	

30	What limitations of medical treatment were explicitly stated in the documentation of the first resuscitation plan?	Not for CPR Not for intubation / mechanical ventilation Not for defibrillation Not for non-invasive ventilation Not for renal replacement therapy (dialysis) Not for ICU Not for HDU Not for vasoactive drugs Not for MET call None Other (please specify)	• Non-invasive ventilation - e.g. CPAP, BiPAP (exclude chronic home CPAP) • Vasoactive drugs - e.g. inotropes or vasopressors such as catecholamines, noradrenaline, adrenaline, vasopressin, dobutamine, metaraminol, levosimendan, milrinone • MET - Medical Emergency Team, Rapid Response Team
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31	What medical treatments were explicitly stated to be allowed in the documentation of the first resuscitation plan?	For full resuscitation/for everything For CPR For intubation / mechanical ventilation For defibrillation For non-invasive ventilation For renal replacement therapy (dialysis) For ICU For HDU For vasoactive drugs For MET call None Other (please specify)	• Non-invasive ventilation - e.g CPAP, BiPAP (exclude chronic home CPAP) • Vasoactive drugs - e.g. inotropes or vasopressors such as catecholamines, noradrenaline, adrenaline, vasopressin, dobutamine, metaraminol, levosimendan, milrinone • MET - Medical Emergency Team, Rapid Response Team
32	Who documented the first resuscitation plan?	Emergency department doctor Admitting medical/surgical registrar Home team junior doctor Home team consultant Palliative care doctor MET doctor ICU doctor Other (please specify)	The aim is to identify who made the primary decision regarding the first resuscitation plan. Note: If patient referred to ICU/ICU outreach and the ICU team made the patient not for CPR/NFR/DNR then consider this also ICU

			If patient was in ICU at the time of the order than consider this ICU even if the home medical / surgical team was involved in the discussion. • Emergency department doctor - medical officer employed to work in the emergency department. • Admitting medical registrar - medical officer undertaking the role of medical registrar which includes admitting patients from emergency department to ward. Does not necessarily work for the consultant caring for the patient once admitted. • Home team doctor - medical officer employed to work as a junior medical officer for the consultant under which the patient has
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			been admitted. • MET doctor - medical officer employed to work as a member of the medical emergency team/rapid response team. • ICU doctor - medical officer employed to work as a member of the intensive care team.
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33	Who was documented to have been involved in decision-making about the first resuscitation plan?	Patient Family Surrogate decision maker Significant other Emergency department doctor Admitting medical/surgical registrar Home team junior doctor Home team consultant Ward staff nurse Ward senior nurse Social worker Specialist palliative care doctor Specialist palliative care nurse MET doctor MET or ICU liaison nurse ICU doctor No one Other (please specify)	
34	Date and time resuscitation plan was last revised/changed	Date - DD/MM/YYYY (e.g. 01/01/2016) Time - 00:00 (e.g. 13:43) Time not documented	
35	Who documented the decision regarding the last changes or revisions to the resuscitation plan?	Patient Family Surrogate decision maker Significant other Emergency department doctor Admitting medical/surgical registrar Home team junior doctor Home team consultant	

		Ward staff nurse Ward senior nurse Social worker Specialist palliative care doctor Specialist palliative care nurse MET doctor MET or ICU liaison nurse ICU doctor No one Other (please specify)	
36	Who was documented to have been involved in decision-making about the last changes or revisions to the resuscitation plan?	Patient Family Surrogate decision maker Significant other Emergency department doctor Admitting medical/surgical registrar Home team junior doctor Home team consultant Ward staff nurse Ward senior nurse Social worker Specialist palliative care doctor Specialist palliative care nurse MET doctor MET or ICU liaison nurse ICU doctor No one Other (please specify)	
37	Is there any documentation that suggests patient or family disagreement about the resuscitation plan?	Yes No Free text	

38	Did the patient receive resuscitation attempts such as CPR, bag mask ventilation, noninvasive ventilation, intubation, adrenaline or other vasoactive drug (eg metaraminol) at the time of or just prior to death?	Yes No n/a	
39	Was CPR administered when the resuscitation plan stated clearly that the patient was NOT for CPR/NOT for resuscitation order?	Yes No n/a	
40	Was the patient invasively mechanically ventilated in ED or ICU at any time during admission?	Yes No n/a	
	Advance Care Plans		

41	Did the patient have a palliative/comfort care ONLY plan documented at the point of admission?	Yes No Free text	Examples may include: • Comfort care / measures • Palliative care • Not for active medical treatment • Supportive care • Not for vital signs / observations • Not for bloods • Not for further investigations • Not for feeds • Not for IV fluids / transfusions
42	Did the patient have a palliative/comfort care ONLY plan documented at any time during the hospital admission?	Yes No	Examples may include: • Comfort care / measures • Palliative care • Not for active medical treatment • Supportive care • Not for vital signs / observations • Not for bloods • Not for further investigations • Not for feeds • Not for IV fluids / transfusions

43	If yes - date and time of first evidence	Date - DD/MM/YYYY (e.g. 01/01/2016) Time - 00:00 (e.g. 13:43)	
44	If a palliative/comfort care plan was documented was it communicated to the patient and/or family?	Yes No n/a	Yes - if there is evidence palliative/comfort care plan was communicated to the patient and/or family.

45	Did the patient receive any of the following investigations/interventions after a comfort care plan was noted?	Chemotherapy Radiotherapy Intubation / invasive mechanical ventilation Renal replacement therapy (dialysis) Non-invasive ventilation Vasoactive drugs CPR Anaesthetic / operation IV antibiotics IV fluids Artificial nutrition Blood tests Medical imaging Blood product transfusions Intra Aortic Balloon Pump (IABP) Cardiac catheter Organ Donation Other (please specify) NoneN/A	• Non-invasive ventilation - e.g. CPAP, BiPAP (exclude chronic home CPAP) • Vasoactive drugs - e.g. inotropes or vasopressors such as catecholamines, noradrenaline, adrenaline, vasopressin, dobutamine, metaraminol, levosimendan, milrinone • Artificial feeds - NG, PEG, TPN • Medical imaging - x-ray, CT, MRI
46	Is there evidence that the treating team change the patient's medications to palliative medications ONLY?	Yes No	Palliative medications - e.g. analgesics, midazolam, haloperidol, glycopyrrolate, hyoscine) / syringe driver, stopping all other medications

47	If yes - date and time documented	Date - DD/MM/YYYY (e.g. 01/01/2016) Time - 00:00 (e.g. 13:43)	
48	Date and time of referral to specialist palliative care	Date - DD/MM/YYYY (e.g. 01/01/2016) Time - 00:00 (e.g. 13:43) Time not documented	
49	Did a specialist palliative care nurse actually see the patient during their hospital admission?	Yes No	
50	If yes - date and time seen by palliative care nurse	Date - DD/MM/YYYY (e.g. 01/01/2016) Time - 00:00 (e.g. 13:43)	
51	Did a specialist palliative care doctor actually see the patient during their hospital admission?	Yes No	
52	If yes - date and time seen by palliative care doctor	Date - DD/MM/YYYY (e.g. 01/01/2016) Time - 00:00 (e.g. 13:43)	

53	What limitations of medical treatment were explicitly stated in the documentation as a result of specialist palliative care involvement?	Not for CPR Not for intubation / mechanical ventilation Not for defibrillation Not for noninvasive ventilation Not for renal replacement therapy (dialysis) Not for ICU Not for HDU Not for vasoactive drugs Not for MET call None Other (please specify)	• Non-invasive ventilation - e.g CPAP, BiPAP (exclude chronic home CPAP) • Vasoactive drugs - e.g. inotropes or vasopressors such as catecholamines, noradrenaline, adrenaline, vasopressin, dobutamine, metaraminol, levosimendan, milrinone • MET - Medical Emergency Team, Rapid Response Team
54	What other professionals were involved in the patient's care?	Chaplain Social Worker Cultural Support Worker Physio OT Dietician Other (please specify) None	

	Medical Emergency Team Calls		
55	Total number of MET calls during this admission	Number options	
56	Date and time of MET review	Date - DD/MM/YYYY (e.g. 01/01/2016) Time - 00:00 (e.g. 13:43) Time not documented	
57	Date and time of first MET review	Date - DD/MM/YYYY (e.g. 01/01/2016) Time - 00:00 (e.g. 13:43) Time not documented	
58	Date and time of last MET review	Date - DD/MM/YYYY (e.g. 01/01/2016) Time - 00:00 (e.g. 13:43) Time not documented	
59	Did the patient die at/during a MET review?	Yes No	
60	Were new limitations of medical treatment documented during or immediately after any MET call?	Yes No	

61	What limitations of medical treatment were explicitly stated in the documentation during or immediately after a MET review?	Not for CPR Not for intubation / mechanical ventilation Not for defibrillation Not for noninvasive ventilation Not for renal replacement therapy (dialysis) Not for ICU Not for HDU Not for vasoactive drugs Not for MET call None Other (please specify)	• Non-invasive ventilation - e.g CPAP, BiPAP (exclude chronic home CPAP) • Vasoactive drugs - e.g. inotropes or vasopressors such as catecholamines, noradrenaline, adrenaline, vasopressin, dobutamine, metaraminol, levosimendan, milrinone • MET - Medical Emergency Team, Rapid Response Team
62	If new limitations of medical treatment were initiated was it documented that these were discussed with the patient and/or family?	Yes No	
63	Did the MET document a recommendation that home medical / surgical team discuss end of life/ goals of care / treatment limitations with the patient / family?	Yes No	

64	Were palliative care / comfort care measures commenced as a result of a MET review?	Yes No	
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